Statement for the Record

of the American Federation of State, County and Municipal Employees (AFSCME)

For the

For the Hearing on
The 2011 Medicare Trustees Report

Before the

Subcommittee on Health
Committee on Ways and Means

U.S. House of Representatives

June 22, 2011

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This statement is submitted on behalf of the 1.6 million workers and retiree members of the American Federation of State, County and Municipal Employees (AFSCME) for the hearing held June 22, 2011 on the 2011 Medicare Trustee Report.

AFSCME and its members are proud of labor's historic role in the creation of Medicare, an indispensable federal social insurance program. Medicare was established and expanded to provide what the private insurance market did not, would not and could not: Affordable, adequate health insurance for America's elderly population and individuals with permanent disabilities. We remain strong defenders of the Medicare program from those who either would directly, or under the general guise of deficit reduction, undermine its foundations by gutting guaranteed benefits or shifting more costs onto beneficiaries.

When President Johnson signed Medicare into law on July 30, 1965, he spoke of the profound promise of Medicare to our nation and its citizens:

> "No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime so that they might enjoy dignity in their later years. No longer will young families see their own incomes, and their own hopes, eaten away simply because they are carrying out their deep moral obligations to their parents, and to their uncles, and their aunts.
>
> And no longer will this Nation refuse the hand of justice to those who have given a lifetime of service and wisdom and labor to the progress of this progressive country."

For today's 47.5 million Medicare beneficiaries and the millions who will depend on this program in the future, the need for Medicare to remain a refuge against financial ruin caused by the caprice of illness and disability rings as true in 2011 as it did more than four decades ago.

Slower than Expected Economic Recovery Undermines Medicare Solvency

Medicare's Hospital Insurance Trust Fund (Medicare Trust Fund) covers inpatient care in hospitals, skilled nursing facilities, hospices and home health care.

The dedicated major source of funding for this trust is payroll contributions paid by workers and employers, interest from the Trust Fund reserves, and income taxes on part of Social Security benefits of upper income beneficiaries.[i] The Trustees project that in 2024 the Medicare Trust Fund will be able to make 90% of payments to doctors and hospitals based on current payroll contributions. Congress could make up the remaining gap through direct appropriations. Last year the Trustees projected a slightly more distant date when the Trust Funds would not be able to pay 100% of the payments. The shortened solvency period for the Medicare Trust Fund is driven in large part by a weak economy that has led to reduced payroll receipts.

The surefire way to fortify the solvency of the Medicare Trust Fund and address the deficit is to improve the economy by creating jobs, closing corporate tax loopholes and requiring the wealthiest Americans to pay their fair share. The fundamental promise of guaranteed benefits in Medicare is not the problem. Myopic proposals for deficit reduction that focus on balancing the budget on seniors and working families are not the solution.

The Affordable Care Act Improves the Fiscal Health of Medicare

Without the Affordable Care Act, signed into law by President Obama, Medicare's solvency would be far worse. The Medicare Trust Fund's reserves would be exhausted in 2016 without the Affordable Care Act. As Medicare's Trustees concluded in their overview in this year's report: "The Financial Outlook for the Medicare Program is substantially improved as a result of the changes in the Affordable Care Act." [ii] Moreover, the improvements to the financial future of Medicare because of the Affordable Care Act were accomplished without shifting costs to seniors or reducing medical benefits.

Significantly, the Affordable Care Act achieves savings in Medicare through a series of payment reforms, service delivery innovations and enhanced efforts to reduce fraud, waste and abuse. It is important to highlight that none of the payment reforms affect Medicare's guaranteed benefit packages. In fact, section 3602 of the Affordable Health Care Act specifically states that the guaranteed benefits in Medicare Part A and Part B will not be reduced or eliminated as a result of changes to the Medicare program.

About $117 billion in Medicare savings from 2010 through 2019 is achieved by halting the growth in wasteful overpayments to private Medicare Advantage plans. However, even under the new health care reform law, in 2011 the Medicare program will on average still pay private plans $1.10 for what it would pay $1.00 for the same beneficiaries under traditional Medicare. This additional spending on Medicare Advantage plans is paid for by the nation's taxpayers and Medicare beneficiaries and threatens the solvency of the Medicare Trust Fund.

Restoring financial neutrality between the rates of reimbursement for traditional Medicare and for insurance companies that offer a private alternative to Medicare, as the independent Medicare Payment Advisory Commission (MedPAC) has proposed for years, would bolster the solvency of the Medicare Trust Fund and control taxpayer costs.

The Affordable Care Act gives federal law enforcement agencies and the Centers for Medicare and Medicaid Services new tools to ratchet up efforts to prevent, detect, fight and punish Medicare fraud and abuse. These programs will bring down costs and improve the solvency of the Medicare program while protecting Medicare's vital guaranteed benefits. According to the Department of Justice, for every dollar we spend combating health care fraud we return four dollars to American taxpayers.

The Affordable Care Act also includes new initiatives and models for reform to control overall rising health care costs that adversely impact Medicare. The nonpartisan Congressional Budget Office (CBO) estimates that repealing or defunding the Affordable Care Act would add $230 billion to the deficit.

Allowing the Affordable Care Act to do its job will improve care, strengthen the fiscal health of Medicare, hold accountable those who perpetuate Medicare fraud and hold down costs for taxpayers.

Eliminating Medicare's Guaranteed Benefits is Not the Way to Reduce the Deficit or Improve the Solvency of the Medicare Trust Fund

The House-passed budget would eliminate the guaranteed benefits available to all beneficiaries under Medicare and that are protected by the Affordable Care Act. Medicare would be radically transformed from a secure defined benefit into an underfunded defined contribution plan. In 2022, the government would offer a 65-year-old $8,000 to purchase a private insurance plan, if available. The federal contribution to Medicare beneficiaries under the new program is designed so that it will not keep pace with rising health care costs. It will lose purchasing power over time, shifting more and more costs onto seniors and people with disabilities each year. According to the nonpartisan CBO, the federal savings associated with this breach in our nation's promise of Medicare would be achieved only because beneficiaries would pay more, not because Medicare coverage would cost less than under current law. CBO estimates that in the first year, premiums and out-of-pocket costs for the affected beneficiaries would double, when compared to traditional Medicare. It is a fundamental distortion of Medicare's to call ending Medicare's guaranteed benefit and shifting costs from the federal government to beneficiaries and their families a way to protect and preserve the Medicare program.

Allow Medicare to Negotiate Drug Prices with Pharmaceutical Companies

The 2003 Medicare prescription drug law explicitly prohibits the federal government from negotiating directly with pharmaceutical companies to lower prescription drug costs for Medicare beneficiaries and save taxpayers money. The cost for prescription drugs has outpaced other health care spending and is expected to exceed spending on hospital care and other medical services in 2010 through 2019. Directing the Secretary to negotiate better drug prices puts the federal government on the side of our nation's taxpayers, seniors and persons with disabilities, leveraging the power of 47 million Medicare beneficiaries to negotiate deep discounts on prescription drug prices. The success of federal bulk purchasing of prescription drugs is well established. The federal government is currently allowed to bargain with the pharmaceutical industry for bulk prices to cover prescriptions provided in a range of federally supported settings (e.g., federal and military prisons, state veterans' homes, public health disaster mobile units and health services for Native Americans) but not for Medicare. Making the Medicare prescription drug benefit more efficient through bulk purchasing and having a single designated administrator of the program, instead of insurance companies, could potentially save taxpayers $200 billion over ten years. These savings could be used to improve the solvency of the Medicare Trust Fund, reduce growth in needed financing for the Supplementary Medicare Insurance Trust Fund and reduce the payments required from states to fund the Medicare prescription drug program.

Extend Medicaid Drug Rebates to Medicare Beneficiaries who are Eligible for Both Medicaid and Medicare

Prior to the creation of the 2003 Medicare Prescription Drug Program, brand-name drug manufacturers paid a rebate for beneficiaries who were eligible for both Medicaid and Medicare. However, when the new Medicare drug program was established, the drug companies no longer had to provide the rebates and got windfall profits as a result. The Medicare Drug Savings Act of 2011 (H.R. 2190) introduced by Representative Henry Waxman with Representatives Sander Levin and Pete Stark as original co-sponsors, would eliminate this special deal that allows drug companies to charge Medicare higher prices for lower income beneficiaries. This legislation could yield $112 billion in savings over ten years. These savings could be used to augment the solvency of the Medicare Trust Fund, reduce growth in needed financing for the Supplementary Medicare Insurance Trust Fund and reduce payments required from states to fund the Medicare prescription drug program.

Allow People between Ages 55 and 65 to Enroll in Traditional Medicare

As Americans near the end of their working lives, they often face uncertainty and significant challenges in securing or maintaining health insurance coverage and, therefore, access to needed care. Medicare is not an option for nondisabled persons until they reach age 65. Studies show that those who are uninsured in the decade before they are eligible for Medicare often need to access more costly health care services and treatments when they finally are eligible for Medicare.

The Affordable Care Act included several options to help these early retirees and pre-Medicare individuals access coverage. While there are a number of policy questions that would need to be addressed to ensure that workers between ages 55 and 65 continue to have access to affordable coverage through their employer, allowing the population that is near eligibility for Medicare to buy into traditional Medicare could add revenue and ensure a better transition into Medicare coverage.

Raising the Age of Medicare Eligibility from 65 to 67 Is Not Sound Policy

The House-approved budget plan would raise the age at which seniors are eligible to receive Medicare benefits. Starting in 2022 until 2033, the budget plan would increase the Medicare eligibility age by two months per year until it hits 67. A recent study by the Kaiser Family Foundation shows that such a proposal could hit beneficiaries, employers and states with higher costs. While the study looked at proposals to raise the age of Medicare eligibility in 2014, the added costs to other stakeholders is illustrative of the harm that would be caused by changing the law to implement the House-approved budget. For example, the study found that changing the age of Medicare eligibility would raise premiums by 3% for those who remain on Medicare and for those who obtain coverage through the health care reform's new health insurance exchanges. In addition, health care costs for employers would increase by an estimated $4.5 billion in the first year as employer plans become the primary payer for 65- and 66-year-olds who would no longer be eligible for Medicare, rather than provide supplemental coverage that wraps around Medicare. Also, costs to states would increase by nearly an estimated $0.7 billion, because 65- and 66-year-olds who would be otherwise eligible for both Medicare and Medicaid would depend on state Medicaid programs.

Raising the eligibility age is not a fix, but will create more harm to our health care system.

Conclusion

The 2011 Trustees Report confirms that Medicare is an amazing success story – providing health security to millions of Americans, even during the remaining economic shockwaves of the worst economic crisis of a generation. Some in Congress are calling for radical changes in the promise of Medicare in order to "save" the program. But they ignore the reality that health care reform has extended the solvency of the Medicare Trust Fund and that the economic recession and high health care costs continue to be stressors on this vital social insurance program. We must let the Affordable Care Act do its job to help control costs and protect Medicare's guaranteed benefits. There are ways to address the deficit and improve the solvency of Medicare's Trust Funds without doing it on the back of beneficiaries or working families.

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i The Supplementary Medicare Insurance (SMI) Trust Fund covers physician visits, outpatient services, lab tests, medical supplies, home health and outpatient prescription drugs. Because premium payments from beneficiaries and general federal revenues contributions are set annually to cover the expected cost of Part B and Part D Medicare benefits the Trustees stated that Part B and Part D accounts of the SMI trust fund is adequately financed. States are required to make unprecedented payments to finance the Part D Prescription Drug Program; AFSCME supports reducing or eliminating these state payments.

ii 2011 ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS at page 6.